Save Print Reset

STATE OF MISSOURI
DIVISION OF PROFESSIONAL REGISTRATION
STATE BOARD OF REGISTRATION FOR THE HEALING ARTS

ASSISTANT PHYSICIAN APPLICATION FOR CERTIFICATE OF CONTROLLED SUBSTANCE PRESCRIPTIVE AUTHORITY

STATE BOARD OF REGISTRATION FOR HEALING ARTS
3605 MISSOURI BLVD, PO BOX 4
JEFFERSON CITY, MO 65102
TELEPHONE: (573) 751-0098
TOLL FREE: (866) 289-5753
TTY: (800) 735-2966

Please complete and return this application and fee of $50, made payable to the Missouri State Board of Healing Arts, to P.O. Box 4, Jefferson City, MO 65102.

ASSISTANT PHYSICIAN NAME (LAST, FIRST, MIDDLE, MAIDEN) (PLEASE PRINT)	MISSOURI LICENSE NUMBER	EMAIL ADDRESS
SUPERVISING PHYSICIAN NAME (PLEASE PRINT)	MISSOURI LICENSE NUMBER	

APPLICANT'S OATH

STATE/PROVINCE OF

COUNTY/PARISH OF

I, _____, hereby certify under oath that I am the person named in this application for a **CERTIFICATE OF CONTROLLED SUBSTANCE PRESCRIPTIVE AUTHORITY**; that all statements I have made herein are true and that I have personally read, reviewed and answered each of these questions; I understand that:

I may prescribe any controlled substances listed in Schedule III, IV, or V of section 195.017, and may have restricted authority in Schedule II - hydrocodone as delegated to me by my supervising physician and as stated in my supervision verification form;

Schedule III controlled substances and Schedule II - hydrocodone prescriptions shall be limited to a five day supply without refill;

I shall not prescribe controlled substances for myself or members of my family as defined in the Board's Rule 20 CSR 2150-2.240(2)(E)9;

I must obtain a registration from the Drug Enforcement Administration (DEA) and the State Bureau of Narcotics and Dangerous Drugs (BNDD) prior to prescribing controlled substances and shall include such registration numbers on prescriptions for controlled substances;

I cannot prescribe controlled substances until I have received a certificate of controlled substance prescriptive authority from the Board and registrations from the DEA and BNDD;

The delegated authority to prescribe is consistent with my and my supervising physician's education, knowledge, skill and competence;

Any limitations on my supervising physician or my ability to practice shall be listed on the supervision verification form;

I have practiced at least 120 hours in a four month period with my supervising physician continuously present;

If my supervising physician changes, then I must provide the Board with a new supervision verification form prior to prescribing controlled substances under the new supervising physician's authority.

All documents submitted with this application or as part of the application process that are original, or duplicated copies of the originals, have not been altered in any fashion whatsoever;

I am the original and lawful possessor of and person named in the various documents and credentials furnished to the Board in connection with this application.

I have read Chapter 334 RSMo, Chapter 195 RSMo, 20 CSR 2150-2 and 19 CSR 30 which contains the Statutes, Rules and Regulations governing the prescribing of controlled substances and the practice of assistant physicians;

I have answered all questions truthfully and in compliance with the instructions provided:

I understand that the application fee submitted with this application is non-refundable and cannot be transferred to another application.

I further state that by filing this application for certificate of controlled substance prescriptive authority, I hereby authorize and consent to have an investigation made as to my moral character, professional reputation and fitness, when in the opinion of the Missouri Board such an investigation is deemed necessary. I agree to give any further information which may be required in reference to my past record. I authorize and request every person, hospital, clinic, community, governmental agency (local, state, federal or international), court, association, institution, or other organization having control of any documents, records, and other information pertaining to me to furnish to the Missouri State Board of Healing Arts any such information, including documents, records regarding charges or complaints filed against me, formal or informal, pending or closed, or any other pertinent data to permit the Missouri State Board of Healing Arts or any of its agents or representatives to inspect and make copies of such documents, records, and other information, in connection with this application.

MUST BE SIGNED IN THE PRESENCE OF NOTARY

APPLICANT'S SIGNATURE	DATE

NOTARY PUBLIC EMBOSSER OR BLACK INK RUBBER STAMP SEAL	STATE	COUNTY (OR CITY OF ST. LOUIS)
	SUBSCRIBED AND SWORN BEFORE ME, THIS DAY OF YEAR	**USE RUBBER STAMP IN CLEAR AREA BELOW.**
	NOTARY PUBLIC SIGNATURE / MY COMMISSION EXPIRES	
	NOTARY PUBLIC NAME (TYPED OR PRINTED)	

STATE OF MISSOURI
DIVISION OF PROFESSIONAL REGISTRATION
STATE BOARD OF REGISTRATION FOR THE HEALING ARTS

SUPERVISION VERIFICATION FORM
(TO BE COMPLETED BY THE SUPERVISING PHYSICIAN)

STATE BOARD OF REGISTRATION FOR HEALING ARTS
3605 MISSOURI BLVD, PO BOX 4
JEFFERSON CITY, MO 65102
TELEPHONE: (573) 751-0098
TOLL FREE: (866) 289-5753
TTY: (800) 735-2966

SUPERVISING PHYSICIAN NAME	MISSOURI LICENSE NUMBER

NAME OF ASSISTANT PHYSICIAN

I hereby certify that I have continuously practiced at the same practice site and continuously supervised the above named assistant physician for the four month period of _____ to _____.
(MONTH/DAY/YEAR) (MONTH/DAY/YEAR)

I hereby certify that I have delegated the authority to prescribe the below listed Schedule III, IV and/or V of section 195.017 and Schedule II - hydrocodone controlled substances to the above named assistant physician (please mark all that apply).

☐ Schedule III, IV and V of section 195.017 and Schedule II - hydrocodone with no limitations;
☐ Schedule III, IV and V of section 195.017 and Schedule II - hydrocodone with the below listed limitations:

☐ Schedule III and IV of section 195.017 and Schedule II - hydrocodone only with no limitations;
☐ Schedule III and IV of section 195.017 and Schedule II - hydrocodone with the below listed limitations:

☐ Schedule II - hydrocodone only;
☐ Schedule II - hydrocodone with the below listed limitations:

☐ Schedule III only;
☐ Schedule III with the below listed limitations:

☐ Schedule IV only;
☐ Schedule IV with the below listed limitations:

☐ Schedule V only;
☐ Schedule V with the below listed limitations:

☐ Other (list below, add additional sheets if necessary);

In addition to the above, please list any limitations on your practice or the assistant physician's practice (i.e. physician is restricted from prescribing Schedule III, physician required to complete triplicate prescription forms, etc.)

I further certify that:

The above named assistant physician shall prescribe any controlled substances listed in Schedule III, IV, or V of section 195.017, and may have restricted authority in Section II - hydrocodone as delegated by me to the assistant physician and as stated in the supervision verification form;

I will confirm that the Board of Healing Arts has issued a certificate of controlled substance prescriptive authority and that the DEA and BNDD has issued registrations to the above named assistant physician, prior to the prescribing of controlled substances;

Schedule III controlled substances and Schedule II - hydrocodone prescriptions prescribed by the above named assistant physician shall be limited to a five day supply without refill;

The above named assistant physician shall not prescribe controlled substances for themselves or members of their family as defined in the Board's Rule 20 CSR 2150-2.240(2)(E)9;

The above named assistant physician must register with the Drug Enforcement Administration and the State Bureau of Narcotics and Dangerous Drugs and shall include such registration numbers on prescriptions for controlled substances;

The delegated authority to prescribe is consistent with each professional's education, knowledge, skill and competence;

Any limitations on me or the assistant physician's ability to practice shall be listed on the supervision verification form;

In accordance with Rule 20 CSR 2150-2.250(1), I will notify the Board within 15 days if my supervision of the above named assistant physician ceases;

I have read Chapter 334 and Chapter 195, RSMo, which contains the Statutes, Rules and Regulations governing the prescribing of controlled substances by assistant physicians.

MUST BE SIGNED IN THE PRESENCE OF NOTARY

SUPERVISING PHYSICIAN'S SIGNATURE	DATE

NOTARY PUBLIC EMBOSSER OR BLACK INK RUBBER STAMP SEAL	STATE		COUNTY (OR CITY OF ST. LOUIS)
	SUBSCRIBED AND SWORN BEFORE ME, THIS DAY OF YEAR		**USE RUBBER STAMP IN CLEAR AREA BELOW.**
	NOTARY PUBLIC SIGNATURE	MY COMMISSION EXPIRES	
	NOTARY PUBLIC NAME (TYPED OR PRINTED)		